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ABSTRACT

The emerging concept of social system psychotherapy is discussed. The development of this approach to psychotherapy represents a gradual evolution in clinical practices from a one-to-one interaction to a multi-person, multi-relational interaction. It also represents the development of a human psychology that has moved from individualistic to social psychology. The techniques of social system psychotherapy are cast in a new model termed the "open" model of treatment in contrast to the "closed" conventional treatment model. In the one-to-one "closed" model the assumption is that psychotherapy will effect changes in the individual to enable him to behave differently in his social fields and social networks. The open model assumes that human is significantly determined by characteristics of the social field and therapy is thus achieved via change in the social system. The two models are not competitive however, but complementary. The develcpment of a social system psychotherapy provides a theoretical and technical base for application to many areas of mental health intervention. (Author/RSM)

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SOCIAL SYSTEM PSYCHOTHERAPY

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SOCIAL SYSTEM PSYCHOTHERAPY

This paper describes the emerging concept of social system psychotherapy, also variously termed network therapy, ecological therapy, and general systems therapy. Although seemingly a radical departure from traditional modes of psychotherapy it will be shown that social system therapy is the extension of a series of progressive steps in the elaboration of psychotherapeutic intervention. Further, the same series of progressive steps taken in personal psychotherapy have also been taken in the areas of mental hospital programs, community mental health programs and organizational change programs. These parallels in the development of "intervention techniques" suggests the development of a new model of mental health services. This new model may be termed the "open" model of treatment in contract to the "closed" model of treatment which is the conventional model. The attempt to conceptualize the progressive enlargement of intervention techniques under the closed model produces serious strains, whereas the open model provides an adequate conceptual fit for framing these therapeutic enterprises.

I. Clinical Development

To begin, I shall trace the development of personal psychotherapy from its inception as a two-person social dyad through a series of steps to the multiple-person, multiple-relation, setting of social system psychotherapy.

Psychotherapy as we see it today has its most obvious derivation from Freud. Primarily grounded in the medical milieu at the turn of the twentieth century it is not surprising that psychotherapy was built upon the medical doctor-patient model. Inherent in that model was the nineteenth century concept of disease--an affliction of an individual, an affliction that required treatment of that individual. Disease was an individual affair, and so became psychotherapy.

The first step away from the explicit one-to-one model appeared some twenty years after the birth of psychotherapy. Around 1920 the child guidance movement began to develop with the inclusion of the parents of the "sick" child in the therapeutic enterprise. The parents, however, were not conceptualized as "patients", nor were the parents involved in "treatment". Rather, the parents were taken into the psychothera-

peutic enterprise under the rubrics of "guidance", "education", "case-work", "social-work", or "ancillary" therapy. This was not incongruous in terms of the existent model of psychotherapy, which was by definition a one-to-one relationship.

The second step in the revision of the original model of psychotherapy was the development of group psychotherapy in the 1930's. The early pioneers in group psychotherapy had acquired their clinical experience in the child guidance movement and had already observed the importance of interpersonal relationships in the behavior of the "sick" child. The early experiments in group psychotherapy were modeled on the one-to-one relationship. Hence group therapy was actually treatment of a person in a group. It was several decades before a thoroughgoing conceptual shift was made to the concept of treatment of all persons simultaneously by the group. The introduction of treatment in a multiple-person setting, and even more so the introduction of the concept of treatment by the participants, occasioned volatile and bitter arguments, for the proponents of the one-to-one model of psychotherapy argued that this form of psychotherapy did not meet the theoretical requirements for the conduct of psychotherapy. Indeed group therapy did not meet the required definitions of psychotherapy, for the definitions of psychotherapy were based on the premises of one-to-one relationships. (70,71)

The third step came with the introduction of family therapy, begun gingerly in the 1940's and reaching real visibility in the late 1950's. (66) The introduction of family therapy grew out of the same intellectual and clinical experiences that had spawned group therapy. However family therapy took longer to develop. One significant reason may be that in group therapy the participants were unrelated to each other, and each group member was identified as "sick". Thus the one-to-one model of psychotherapy was strained but not broken. However family therapy introduced major problems. It was no longer clear who was sick and who was well in the therapeutic setting, nor indeed who was the patient. Further, the participants were intimately related to each other. This latter factor proved a challenge to traditional ideas of the one-to-one model, such as the development of transference, regression, lack of destructive feed-back, etc. It was recognised that family therapy was not just group therapy with a family group, but perhaps the introduction of a therapeutic technique sui generis. (36,38)

The fourth step was the introduction in the early 1960's of a further seeming confusion. Clinicians began to organize multiple families into one group for therapeutic purposes, perhaps four to six families meeting together, comprising some 16 to 25 people, both related and unrelated to each other. (7,12,19) A similar mix was produced in the development of married couples group psychotherapy in which four to six married couples met together as a grou. (33) As before, the therapeutic situation involved persons who were related in real life, but in addition it included persons who were totally unrelated to each other. At this point it seemed very difficult indeed to conceptualize this mode of psychotherapy under the traditional theories of psychotherapy developed from the one-to-one situation.

The fifth step occurred less explicitly than the rest. It began in the 1950's with the development of home visitation treatment programs, where the mental health professional went into the home of the "sick" person to treat him, and perforce to work with the family of the patient. (69) This was close to the one-to-one model, but even the shift in setting raised conceptual issues. (75) Shortly however, the home visit was rapidly expanded in scope. MacGregor et al (58) introduced the concept of "multiple impact" family therapy where a team of professionals spent several days in a home with the entire team and family together. A variation, but significant one, was the conduct of an entire course of family psychotherapy in the families' homes. (81) Interestingly, these therapists reported that friends, relative, neighbors, would occasionally be included in the family sessions because of happenstance, invitation by the family, or even specifically invited in by the therapist because the "extra-familial" person was noted to play an important role in the dynamics of the family. Similarly, other therapists have reported on experiences in living in the homes of families in treatment, or making extensive visits to the homes of families where they participated in various family functions that included friends, relatives, visitors, etc. (39,51,55)

The sixth and final step has been to formalize contacts and relationships between family members and non-family members--to include in the psychotherapeutic situation any number of persons who are related by either kinship, friendship, or functional relationship (employer, etc.) or community residence. (3,4,30,56,72,73,95,96) This social net-

work of relationships then has been made the focus of the psychotherapy. Ross V. Speck, to my knowledge, first made explicit use of this frame of reference for psychotherapy and coined the term "network therapy" (78,82,83,84,85) Edgar Auerswald and other workers refer to this approach as "ecological" therapy (6,40,92) whereas other clinicians link this therapeutic method to general systems theory. (42,52) In all these instances, the focus of therapeutic work has shifted to the social system of the individual patient, and the therapy of the patient is achieved via change in the social system of the patient.

Without involving ourselves in the intermediary steps, it seems readily apparent that social system therapy as the current end-stage of psychotherapeutic techniques stands a far distance from the theory and technique of psychotherapy as defined and elaborated from the one-to-one situation. To attempt to "fit" these latter psychotherapeutic techniques into the conceptual schemata derived from the one-to-one model of psychotherapy seems not only herculean, but perhaps more importantly, merely an inappropriate effort. Rather, I shall suggest that these psychotherapy innovations call for the development of a new model of psychotherapy that is appropriate to these techniques. This model, which I call the "open" model would not replace the "closed" model, but would complement it. Before proceeding to examine these two models, however, we will review the rationale for the development of these extensions of psychotherapy. Further, examples from other areas of mental health intervention will demonstrate that the extension in psychotherapy reflects part of a broader extension of mental health intervention concepts.

II. Theoretical Development

Gardner Murphy has observed that from the time of Aristotle until late in the nineteenth century psychology was the study of individual minds. Group interaction and interpersonal relations were problems for the historian, the moralist, the jurist, the political economist. Psychotherapy was born in an intellectual era in which perhaps only a one-to-one model of psychotherapy could have been built.

However a social psychology of human relationships built on the work of William McDougall, Cooley, Durkheim, Giddings, Ross, Tonnies, and especially George Herbert Mead

began to stir an intellectual ferment that was to shake psychological thinking loose from its individualistic moorings. (59)

In the 1920's social scientists began to study 'natural groups' in society, based on the conviction that the solution to "social problems" could be facilitated by the study of social interaction and normal social groupings. This empirical research approach was translated into social work practice with groups. But interestingly, the "social group work" method has remained defined as <u>not</u> psychotherapy. The empirical study of natural groups in the community also gave rise to social welfare and social action programs. Yet here also such intervention was not defined as psychotherapeutic. In both instances, because specific people were not identified as "sick", these types of intervention were not seen as having personal therapeutic potential. More recent evaluations to be cited suggest that therapeutic potential was present, but not exploited.

Finally, in the 1930's Kurt Lewin began to formulate his now famous field theory which has undergone a variety of permutations. The variations are tangential to this discussion. The major emphasis however is central. Namely human behavior cannot be adequately conceptualized apart from ongoing human relationships. With this central concept in mind we can then approach the whole issue of psychotherapeutic intervention. The one-to-one model assumes that treatment can ignore the patient's ongoing human relationships, and it assumes that one-to-one intervention techniques are sufficient to produce therapeutic success. This of course may be assumed to hold true for <u>certain</u> cases of human predicament, but not <u>all</u> or perhaps even <u>most</u> cases of human predicament.

The early development of multiple-person therapeutic situations may be seen as an application of general principles of Lewinian field theory and the subsequent elaboration of interpersonal role relationships exemplified in small group sociology, social psychology, and role theory. In brief, persons operate in a social field which to a significant extent determines behavior. Thus one can create a social field which can be of therapeutic benefit to the emotionally disturbed person. Cody March, pioneer in group therapy methods, coined a succinct motto of this theory: "by the crowd they have been broken; by the crowd they shall be healed."

However, this concept of social field is an impersonal concept. The destructive

or beneficient effects of the social field are not dependent on the particular personalities or relationships of the individual persons that comprise the field--rather it is the sociological structure of the field that determines its impact. Thus Cody March was quite correct when he used the word "crowd" in his aphorism.

When however the focus of clinical concern shifted to families and persons linked together by their instrumental and affective relationships to each other we observe a more complex and perhaps different socio-dynamic. For here we have not only the effects of impersonal sociological group function, but also the effects of instrumental and affective linkages that exist between members.

Edward Jay, (43) an anthropologist, in his paper "The Concepts of Field and Network in Anthropological Research" attempts to differentiate between the impersonal social field and the personal social network. He suggests that social field be used to refer to an egocentric system: "There is no hierarchy, no nucleated denser focus of relationship or center. The only center would be the unit from which we are looking outward in a given arbitrary distance. Every unit is in this sense a center. We might say that such a system is always egocentric. . . the units of the field may be individuals, families, communities, or other social aggregates, but the field as such does not constitute a 'group' with corporate qualities and cohesiveness." In contrast Jay defines a network as the totality of all the units connected by a certain type of relationship. A network has definite boundaries and is not egocentric, and a major focus of study of such a social network, then, is on the nature and quality of these specific connecting relationships that set the particular pattern of the network. For example, a family is a social network that is characterized primarily by specific affective connections, whereas a factory work team is a social network characterized primarily by specific instrumental connections.

What we have observed then over the past 30 years is a step-wise recognition of the social network in which the patient is embedded; moving from parents and child, to nuclear family, to extended family, to finally a complex social network that may include nuclear family, various kin, friends who have "affective" links, and persons like ministers and bosses who have "instrumental" links. (15,41,49,50)

The major conceptual shift so far as therapy is concerned revolves around the focus of therapeutic intervention. In the one-to-one "closed" model the assumption is made that psychotherapy will effect change in the individual that will enable him to behave differently in his social fields and social networks. Whereas, in the multiple-person "open" model we assume that by tightening and loosening the affective and instrumental linkages that exist in the network different options for behavior will be presented to the "patient" and consequently the patient will behave differently. Thus the focus of psychotherapy in the open model is to change the interactional characteristics of social network. This model explicitly assumes that human behavior is significantly determined by the characteristics of the social field or social network, hence the therapeutic emphasis lies here, rather than on changing the individual per se. (17, 22,23)

There are at least two major corollaries to this thesis. First, in the one-to-one closed model the norm of normality is essentially an <u>idealistic</u> one, i.e. the mature genital character, whereas in the open model the norm of normality is an <u>adaptive</u> one, i.e. capacity to operate effectively in the person's social field and network. Second, the closed model focuses on characterological change, whereas the open model focuses on behavioral change.

The rationale for a focus on social networks also arises from a series of empirical studies. Anthropological studies of kinship systems had demonstrated that the kin social network in primitive societies was a major determinant of affective and instrumental relationships. The same was shown to hold for the agrarian, small town enclaves that characterized the living patterns of western societies until the late 19th century. However with industrialization and the dramatic shift of the population balance to large city living patterns it was observed that traditional kinship relationships were severed both by geography and rapid shifts in social and economic status between members of the kinship system. By the 1940's sociologists such as Talcott Parsons concluded that the former affective and instrumental functions of the kinship system had vanished and been replaced by social organizations. (27) It was concluded that the extended kinship system typically had been replaced by the so-called nuclear family, i.e. mother, father, and pre-adult children. It was concluded that the nuclear family could not provide all of

the necessary affective and instrumental needs necessary for effective family function, and fears were expressed for the demise of the nuclear family as an unstable social structure.

However, the pessimism of the 1940's did not bear fruit as even more industrialisation and urbanization occurred in the subsequent decades. In turn, a number of more refined studies of urban kinship systems demonstrated that the earlier sociological view of the nuclear family required revision. (88) It was shown that in working class and even in lower class families in urban areas that a kinship system was present and powerful. Further it was shown that kinship systems existed in urban middle-class and upper-class families. (1,2,18,31,32,37,48,77,80,90,91,99)

Thus at the present time we have extant at least four variants of kinship systems.

1. The traditional extended family structure that is an interdependent social and economic unit, each nuclear subfamily living in geographic proximity and depending on the extended kin for major services in life.
2. The dissolving or weak family in which most kin functions have been taken over by large-scale formal organizations, leaving the family with little do---all that is left is a very tenuous husband and wife relationship.
3. The isolated nuclear family, composed of husband, wife, and small child. Fewer, but essential function are concentrated in the nuclear family, sufficiently powerful to provide stability.
4. The modified extended family structure consisting of coalitions of nuclear families in a state of partial dependence.

In most of the sociological literature the study of kinship systems has been confined to the study of blood-related kin, however. Yet studies from a socio-psychological perspective have demonstrated that in urban settings, and especially among middle-class families the kinship system, usually of a modified extended type, consists not of blood kin but of <u>affective kin</u>. That is, friends, neighbors, and associates in informal social groups assume the functions of blood-kin in an affective and instrumental netourk of relationships. In summary then, in urbanized living patterns the blood kin system has been replaced by a friend, neighbor, associate, kin system. (9,29,67,76,86,

87,89,97,98)

These kinship considerations assume clinical importance both in terms of the social network conditions that may produce symptomatic behavior, and as a social system to which therapeutic efforts may be addressed.

The importance of family relations in the genesis of disturbed behavior in one member of the family has been extensively discussed in the family therapy literature. The family dynamics involved, however, may not just be the dynamics of the nuclear family. For example, Mendell et al (61,62,63) have reported several studies on the communication of mal-adaptive behavior over multi-generations, in one instance over five generations. They conclude from their studies, that the focus of therapeutic intervention must aim at this ongoing social system: "When the individual comes to a therapist for help, we assume that he is admitting the failure of his group as an effective milieu in which to find the solution he seeks (to his problems). Our data suggest that the individual seeking help frequently approaches the therapist to protest against the ineffectiveness of the group to which he belongs".

The importance of kinship systems as a framework for psychotherapy is emphasized in the clinical treatment of families with schizophrenic members, where it has been noted that affective kin relations often play a determinative role in the behavior of nuclear family members. In some instance the schizophrenic family is unable to utilize the affective and instrumental resources of a kinship system, whereas in other instances the kinship system serves to perpetuate and reinforce psychopathological family dynamics. (54)

The lack of an effective kinship system or mal-function in the kinship system has been suggested as a etiological factor in nuclear family dysfunction.

A study by Kammeyer and Bolton (45) compared a group of normal families and a group of families applying for treatment at several family service agencies. They found that the client families, by comparison, had fewer memberships in voluntary associations, fewer friendships with relatives, and fewer relations living in the same community.

In another, more extensive study, Leichter and Mitchell (53) focus on the necessity for a diagnostic focus that extends beyond the nuclear family: "We have argued

that family diagnosis must not end with the nuclear family, because the family is no more a closed equilibrium system than is the individual. . . Knowledge of the relationships between the family and its external environment are vital. . . this knowledge applies to kin, to occupational associates, to friends, and other nonfamilial relationships Leichter and Mitchell then turn to discuss treatment intervention. They suggest that the kinship network might be the appropriate unit of treatment, yet, interestingly, though writing in 1967, they were apparently not aware that clinicians were actually embarking on a treatment course they could only suggest: "Perhaps a group of kin could even be an effective unit of group treatment. This unit would differ radically in some of the characteristics of externally impersonal relationships that pertain in group therapy. . .A group of kin might be an effective unit of treatment precisely because they are interrelated, and changes in one would have actual relevance for changes in the others. . .the possibility that this unit might be effective in some instances is no more far-fetched than the notion that the family rather than the individual is sometimes the appropriate unit of treatment. . .The notion that under some conditions it might be beneficial to treat more extended segments of the kin network sounds removed from present thinking, but is a possibility that should not be arbitrarily excluded".

It is of historical interest, however, that N.W. Bell (8) had suggested the kin social network as a focus of psychotherapy as far back as 1962. He observed that "well" families has achieved resolution of the usual problems of ties to extended kin, and therefore had the resources of the kin available. Whereas "disturbed" families had been unable to resolve conflicts with the extended kin outside the nuclear family. Bell observed that the pathological families used the extended families 1. to shore up group defenses, 2. provide a stimuli for conflict, 3. as a screen for the projection of nuclear family conflict, 4. as competing objects of support.

Meanwhile, a number of family sociologists had been pointing to the existence of the modified extended family system as a potential mental health resource. (3,20, 56,87,89,93,97) Eugene Litwak (57) suggests that mental health professional avail the kin network instead of trying to provide solely professional treatment resources. Speaking of Family in the modified extended kinship sense he summarizes: "there are several

classes of situations where the trained expert is of little use: in situations which are not uniform and where the minimal standards set by society are not involved. By contrast, the formal organization might be more effective in uniform situations where high social values are involved. The question arises as to whether the family as a primary group might not be superior to the formal organization in these areas. . . the family structure is able to deal more easily with the idiosyncratic event because the family has more continuous contact over many different areas of life than the professional organizations. . . the family has speedier channels for transmitting messages that had no prior definition of legitimacy. . . it is less likely to have explicit rules on what is and what is not legitimate, it is more likely to consider events which have had no definition. . . In most instances the bureaucratic agency in the extreme case is prevented from considering events without a priordefinition of legitimacy by law. In most instances the bureaucratic agency is specifically prevented from acting, by explicit rules which define the area of legitimacy ahead of time. . . The family, can define much more uniquely what is to be valued. The number of people who must cooperate are much fewer, and because they are involved in affectional relations, they are most inclined to accept each other's personal definition values."

Translated into clinical idiom, Litvak's observations suggest that the modified extended family network may provide a more potent therapeutic organization in some instances than the placement of a nuclear family in a bureaucratic mental health treatment system.

The application of therapeutic intervention however will depend on the clinician's assessment of the type of kinship system which exists for a given family, and furthermore, then apply therapeutic intervention techniques applicable to that type of kinship network.

The most obvious example of the problem is to survey most of the clinical literature on family therapy. Almost all such literature only describes the psychotherapy of a nuclear family. Yet the typical family of the slum ghetto is probably of the dissolving-weak type. The use of nuclear family psychotherapy techniques become inappropriate and useless when applied to dissolving-weak family and kin systems. The best illustration

of this is given in the work by Minuchin et al (65) with slum families in New York and Philadelphia. They found that there were a variety of sub-types of dissolving-weak family and kin systems, none of which were like the typical nuclear family so familiar to most upper middle class American psychotherapists and clinics. Minuchin and his group found that they had to devise strikingly different methods of therapeutic intervention with these dissolving-weak family and kin systems.

Another clear example of the difference which kin social network makes in planning therapeutic intervention is provided by the work of Elizabeth Bott from England. (13,14) Based on observations of family life and the social network of families she outlines several different types of nuclear families each of which has a different functional relationship to its social kin network. For our purposes we shall consider only two polar extremes: the close-knit family network and loose-knit family network. (see Figure 1.)

The characteristics of those two polar types will be categorically compared.

1. The close family lives in geographic proximity to area of rearing and blood kin.

   The loose family lives geographically distant from area of rearing and blood kin.

2. The close family is linked along gender lines with preceding and succeeding generations. There is little socio-economic change from generation to the next and social values are expected to continue from one generation to the next.

   The loose family is not linked along gender lines, with primary loyalty being established between marital partners. The nuclear couple typically have changed socio-economic status from parents and kin. Children are related mutually to the marital couple. Values are not transmitted from generation to the next, and children are expected to separate from the marital pair when adulthood is reached.

3. The close family has a high rate of intergenerational visitation and primary relationships are along kin lines rather than between husband and wife.

   The loose family has a low rate of intergenerational visitation and primary relationships are between husband and wife. Visitation here is with other nuclear marital pairs.

4. In the close family husband and wife have clearly defined instrumental tasks based

on gender. Satisfactory sexual relations are not requisite for marital stability. Child rearing is defined by the kin system on each side, not by the marital pair. In the loose family husband and wife have more diffuse instrumental tasks, the bond is primarily affective and satisfactory sexual relations are a major component of the bond. Child rearing is usually disparate from kin tradition, and is defined mutually by the marital pair.

5. In the close system, the primary unit is the kin system of which the nuclear family is a sub-system. Family values and interaction are determined by the kin system. In the loose system, the primary unit is the nuclear family. Family values and interaction are determined by the nuclear family, usually disparate from the blood kin system. However, the affective kin system of neighbors and friends, also loose-knit nuclear types, may be important parts of a social system that defines values and behavior.

In summary, family therapy as we know it was devised to treat loose-knit types nuclear families. Family therapy brings this nuclear family together, as a coherent social system to effect change in that family social system. Here, if network therapy were to be employed one would look to neighbors and non-blood kin friends as the actual operant kin system that might influence the behavior of this nuclear family.

However the close-knit family is quite a different situation. Here, were one to assemble this nuclear family for a typical family therapy session to help them work more effectively together, the probability is low that success would be achieved. For in the close-knit system the nuclear family is not a coherent functional social system. Here the functional system involves the parents, grandparents, blood-kin, and to some extent close friends or associates. It is this sort of family situation to which network therapy might most fittingly be applied.

Examples of Other Therapeutic Systems Analagous to the Network System:

To look back briefly on the progression outlined, the concept of psychotherapy has moved from a concept of psychotherapy as an intervention with one person to change his character structure to a concept of psychotherapy as an intervention with a social system that in turn changes the options, roles, and functions of one person as part of a multi-

person field of behavior. The same progression has occurred in three other systems of intervention. These four systems may be seen to reflect a more general pattern. Hence each will be sketched out to illustrate the general principle.

If the individual psychotherapy system is the first, then we may call the mental hospital system the second. In this system the intensive therapeutic approach to the patient began with one-to-one intensive psychotherapy of a patient who lived on a hospital ward. (An example might be Frieda Fromm-Reichman's intensive psychotherapy of schizophrenic patients at Chestnut Lodge.) Then attention began to focus on the quality of the ward living experience. Attempts were made to humanize ward living experiences with open-door policies, social activities, etc. This might be termed the creation of a therapeutic milieu. Conceptually the next step was the introduction of group discussion among patients, and patient self-government programs. Following this came a variety of types of intensive ward or group psychotherapy programs. And finally came the concept of <u>milieu therapy</u>, that is, the deliberate management of the entire social system of the hospital in which the psychotherapist does not treat a specific patient, but focuses on directing the social system so that it will operate in a therapeutic fashion. (24,25,26) This shift has been so pronounced that some would not describe milieu therapy as psychotherapy, but rather as <u>socio-therapy</u>. This labelling maneuver may be seen as one attempt to deal with failure of the one-to-one closed model of psychotherapy to provide an adequate conceptual base for this broadening of the intent of psychotherapy.

The third system may be called the community mental health system. Early attempts at intervention in the community to improve the mental health of community members was based on the identification of individual persons in distress. Perhaps classic individual case-work in community welfare agencies may be seen as a prototype. Here attempts were made to help persons with their rent, child-care, clothing, food, etc. The second step was taken with the development of local community groups to deal with common problems, and to assist natural community groups to function more effectively. This may be seen as the classical group-work approach. And the final step has been to use community mental health programs to launch broad-scale social action programs aimed at changing basic

social programs, social policies, social organizations of an entire community. The critics of such community mental health endeavors rightly state that social action does not seem to fit the paradigm of traditonal mental health concerns. However, from a social systems viewpoint, such social action foci would be a logical part of the model of intervention. (9,20,28,35,47,75)

The fourth system might be called the educational-organizational system of intervention. I have here in mind the development of the programs of the National Training Laboratories. The NTL training laboratories began as an attempt to provide group sensitivity experiences that would change the personality function of educators and work supervisors. It was soon observed that the benefits of this experience focused on change of the individual was quickly vitiated by the social system requirements to which the individual returned. The next step at NTL was to bring members of the same educational or work group together for group experiences. This proved more effective, but still it was observed that a small work group also returned to a larger organizational structure. Thus the final step taken by NTL has been to develop programs of social system intervention that aim at producing changes in the structure of the entire organization. Thus the movement here has also been a shift from intervention with the individual to intervention with the social system. (4,15,34,68,94)

In summary, in this section I have attempted to develop a rationale for a social system focus of psychotherapy. This focus in psychotherapy is in concert with a more general frame of reference, including examples from three other systems of intervention. As suggested at the outset, this progression may be seen as the clinical reflection of a larger scientific movement, namely a general human psychology which in 1900 framed human psychology as an individual matter and has since moved toward a human psychology which is a social psychology. As a corollary then, we have moved from a model of psychotherapy as an individual enterprise to a model of psychotherapy as a multi-person enterprise.

III. The Open Model of Psychotherapy and the Closed Model of Psychotherapy:

In this section I shall briefly outline some distinct differences between a closed and open model of psychotherapy. My aim is to illustrate that the two models do not compete, but rather are complementary models, for each is addressed to different psycho-

therapeutic goals.

The open model of psychotherapy is actually the oldest. It is the model of the shaman, the primitive healer, the folk healer. In his studies on primitive healing procedures Ari Kiev (46) has suggested that psychotherapy is a public affair----hence my use of the label "open" psychotherapy.

In the primitive society if a member became "sick" this was matter for public concern, for a necessary worker was lost to the small society. Hence it was in the interest of everyone to see to it that the sick person was restored to function. There was little margin for functionless members of the community, everyone was needed to keep the small society functional. When a person became emotionally "ill" there was a generally accepted societal explanation for the cause of the illness. Further, everyone in the small society knew what healing procedures needed to be carried out. And everyone knew what the shaman would do in his healing rituals. Further, the entire small society might actually participate in the healing rituals. Kiev, and others, have provided examples of the shaman-society healing rituals. (93)

The goal of the healing was to restore the ill person back to his usual mode of operation and function in the social system. There was no questioning of the values or patterns of function of the social system. In other words, there was a value consensus between healer-patient-society. And there was a healing consensus between healer-patient-society. And the healing procedures were a multi-person enterprise that involved healer-patient-society. (10,11,60,79)

In contrast, the "closed" model of psychotherapy developed with quite a different rationale. The goal was not to help the patient return to function in his social system in the same old way. Rather it was to help the patient to examine his social system, examine his pattern of function in his social system, and perhaps function in a different social system altogether.

Now the closed model could only come into existence in the face of several other social considerations. First, the person was not immediately required for the society to function, he could remain dysfunctional for extended periods of time. Second, the person had available to him a variety of value systems from which he could choose, i.e. he did not live

in a one value society. And third, the person had available alternative social systems into which he could move. (44)

In the open model privacy is anti-therapeutic, for it is the public pressure, public response, and public support that enables the person to move rapidly back into his accustomed social function. In the closed model privacy is paramount, for it is the privacy which enables the person to achieve distance and perspective on his behavior in his social system. It is the privacy of the closed model that allows the patient to explore alternatives without public pressure, with public response, and without public support.

Thus we can see that if our psychotherapeutic goal is rapid return of a "sick" person to accustomed social function then we may choose the open model to capitalize on the "public" that comprise the patient's social system. This is social system therapy. It is a public therapy. The difference between the primitive shaman and the social system "open" model psychotherapist, is that the psychotherapist may aim at changing some characteristics of the social system, not merely using the social system as does the primitive shaman.

If our psychotherapeutic goal is change of personality with the concomitant development of capacity to choose among alternative social systems then the closed model of psychotherapy in the traditional psychoanalytic sense becomes the model of choice.

The advantage of having two models of psychotherapy is that the psychotherapist may be freed from the attempt to make very different types of therapeutic interventions fit into a model that is inappropriate, and hence experience conflict over a variety of technical, social, and ethical issues. Further, the psychotherapist can clearly take advantage of the strengths of either model as indicated instead of compromising one model to achieve the goals of the other model.

The differences between the two models are charted in Figure 2 for comparative purposes.

IV. A Case Example of Social System Psychotherapy:

Up to this point most examples of network therapy in a psychotherapeutic context have been based on work with psychotic patients, in which the nominated patient was dealt

with therapeutically in the context of a family group or community group in which various members of kinship systems were included. Other examples, although less clinical, come from the work of NTL with organizations.

In this case, I shall describe the use of the social system therapy concept in which various members of the social network were the focus of the psychotherapeutic intervention, while the nominated patient was not dealt with directly at all, and where the various segments of the network were never dealt with as an entire group at one time. This example is deemed important as an illustration of the social system therapy concept used explicitly without a focus on a nominated patient. Further, it illustrates an attempt to specifically deal with a social network in its various sub-sets without attempting to deal with the entire network at one time.*

On December 17 the University Hospital Psychiatric Consultation service received a consultation request from the Orthopedic ward regarding an 18 year old single white girl who was being treated for multiple injuries sustained in a motorcycle accident. The previous evening the patient was found to be overly drowsy, slow to respond to conversation, and with slurred speech. It was determined that she had taken an over-dose of sleeping medications which she had been accumulating surreptitiously. When questioned she said: "It didn't matter, I don't want to live. Don't bother me. I want to join my boyfriend, my husband to be."

The patient is a high school graduate who lives in a suburb of a large metropolitan area. She is the second sibling, a brother 20 years old is a University student. Her father is 53, her mother 49. Currently the father is engaged in a business project and spends much of his time away from home. The family has been active in the Presbyterian church, however, since junior high school the patient has overtly rejected the family church except for social contacts with the young people of the church.

In the past several years the patient has been attracted to the hippie movement, paints psychedelic art and dresses in hippie fashion. Her friends like hippie fads and she had adopted a "drop-out" attitude toward life and her family.

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* J. David Kinzie, M.D. provided assistance in formulating the clinical case material.

In the year prior to admission she had been dating a boy 20 years old who had similar interests and attitudes. The relationship was considered serious by both families. During the summer prior to her accident the two young people worked together at her parents' resort business, but their work was considered unsatisfactory because they were frequently absent on motorbike larks. The girl's parents did not approve of the relationship and openly expressed their dislike of the boyfriend. In the latter part of the summer the girl was sent on a trip to New York with her brother to get her away from the boyfriend. However on her way home she arranged to visit friends in Wyoming and surreptitiously met her boyfriend there. They remained in Wyoming together against the wishes of both sets of parents. On October 7th, while riding a motorcycle together they were involved in a head-on collision. The boyfriend was killed instantly while the patient sustained serious injuries, including an acute brain concussion, fractures of mandible, fibula, femur and internal abdominal injuries that required abdominal surgery. A large body-encasing cast was placed on her for the orthopedic injuries.

Her parents immediately went to Wyoming to join her. Her physical status was satisfactory but her emotional status was difficult to determine. The hospital staff were reluctant to inform her of the boyfriend's death, as were her parents. But someone on the hospital staff inadvertently told her, much to the dismay of her parents and the attending physicians. Her response was neglibile and she appeared apathetic most of the time. On December 4 she was transfered to the University Hospital for further orthopedic treatment.

At the University Hospital she was polite but distant to her parents, as well as to the nursing staff. The one relationship that seemed meaningful to her was that with orthopedic resident in charge of her care. On the evening of December 16 this resident had made arrangement to change the traction on her leg. She stayed away from a ward Christmas party to await him. However on the way to the hospital the doctor himself had an accident. The patient was informed of this in somewhat ambiguous terms since the extent of his injuries were not known. The patient showed no demonstrable reaction to this event. But one hour later she was found in the depressed suicidal state described. (In retrospect the accident of the physician reactivated the same reaction as the death

of her boyfriend, the physician having been ascribed a transference determined role, i.e. she and he had a relationship that existed in opposition to the rest of the world.)

The ward staff found the girl increasingly incooperative the next morning and during the day the medical staff and nursing staff began to become increasingly angry with each other for failing to establish rapport with the girl. A psychiatric consult was then requested. On the second day post-suicide attempt the psychiatric resident interviewed the girl, but she refused to talk to him and told him to leave her alone. He wrote a dejected consultation note and told the orthopedic staff that he could be of little use to them because the patient would not talk to a psychiatrist. Subsequently the girl seemed to become more lethargic. The staff concluded that she was surreptitiously taking more pills, that they assumed were being brought in by her hippie friends. She was therefore placed in an isolation room and forbidden visitors. Her mental condition seemed if anything deteriorating, although so little communication could be established with her that nothing was known for certain except her obvious behavioral communications.

At this point the orthopedic faculty in charge requested assistance from me in my role as faculty supervisor of consultations. I interviewed the girl late on the second day post-suicide attempt. I found that with great effort I could and did establish communication with her, but she was resolutely negativistic toward anyone she perceived as part of the establishment or represented any type of authority. I was able to find out that she did like to talk to the Presbyterian minister from her parents' church, and she was angry at not being able to visit with her hippie frinds, several of whom also had a social relationship with the same Presbyterian church.

At this point I elected to explore the characteristics of the social network of this girl as they existed at this point both within the hospital and outside it. A plan was worked out with the psychiatric resident assigned to the case to systematically interview all the persons we could determine had some current relationship with the girl.

First, we found that the medical staff and the nursing staff had given up on any attempt to establish a working relationship with the girl. Each staff blamed the girl for creating a problem with the other staff. Thus we found the girl was being made the

scapegoat for interstaff conflict. (64)

Second, we found that her parents and the dead boyfriendb parents were both trying to visit her frequently everyday, but were avoiding each other in the hospital. Each set of parents blamed the other parents for the fate of their child. However, each set of parents also blamed the girl for her current behavior which they asserted made it impossible to talk to the other set of parents. Thus the girl was the scape-goat for the inter-family conflict.

Third, we found that the Presbyterian minister was interested in talking with the girl, as were her hippie friends whom he knew. However, in view of the suicidal attempt, neither the minister or the friends felt that they should now interfere with staff or parents. Further, they were fearful that if they visited with the girl they might somehow precipitate further depression and another suicidal attempt.

Fourth, we found that the medical staff and nursing staff had no communication with either set of parents, the minister, or the friends. Both the hospital staff and the kin and friends were reluctant to approach each other. The staff viewed the family and friends with suspicion as possibly contributing to the girl's depression, while the family and friends were suspicious of the hospital staff as being hostile to them and not caring for the welfare of the girl.

At this point the psychiatric resident had made frequent visits to the patient in an attempt to establish a therapeutic relationship. But she remained obdurately hostile and uncommunicative. A second resident took over the case and he fared no better. However, with the information at hand regarding the scape-goating and blockades in the socia network, we decided to inform the girl that we would not conduct any psychiatric treatment with her, but that the psychiatric resident would be visiting with her family, friends, and staff to work out a hospital program for her.

Figure 3. outlines the social network of the patient as it existed at the time that a program for social system therapy was planned. First, a meeting was arranged with the minister at his church that included all of the hippie friends that had visited the girl. The girl's problem was thoroughly discussed with this group and they agreed to a program of daily visitation with the girl. Second, several meetings were arranged with

the medical staff and nursing staff together and separately to outline the problems in her social system which had been uncovered. The issues of inter-staff conflict were aired and discussed. Concrete plans for specific nursing care were devised and reviewed daily with both the medical and nursing staff. Further, meetings were held between the two sets of parents and the medical and nursing staff to discuss the management of the patient that had been established. Specific roles for the behavior of the parents were established. Subsequent meetings between the parents and the hospital staff were held to maintain the agreed upon role contracts. The hospital staff also met with the minister and the hippie friends, and their roles were defined and agreed upon by both groups. Third, meetings were held with each set of parents and with both sets of parents together. Their mutual hostilities and projections were explored and resolved in several joint sessions. Their mutual roles in visiting with the girl were outlined and agreed upon. Subsequent meetings were held with the parents to reaffirm and sustain their roles with each other and with the girl.

All these network contacts were made within several days. Within the first week the girl became brighter, more communicative, less depressed. However in the second week she became overtly angry and hostile toward everyone instead of her former passive and intropunitive self. During the period she made a second abortive suicidal attempt which everyone handled with reasonable aplomb. Thereafter she became demanding and engaged in very active, albeit hostile, interactions with many people. Her clinical depression rapidly cleared and by the fifth week of this sequence was able to go home on a week-end pass, which was uneventful. Her parents felt that she had returned to her former emotional self of the past summer. The relationship with her parents was obviously conflictual, but parents and girl both were able to cooperate with each other. A subsequent surgery and hospital stay in February was uneventful and the patient was considered by the hospital staff to be a "good" patient during her second hospitalization. Subsequent follow-up in March revealed that the girl had had no recurrence of her clinical depression and was making a satisfactory convalescence. The parents reported that the human interactions that had been generated during the suicidal and depressive period had provided a vehicle for resolving some of the long-standing conflicts that had been present

in their relationship with the girl.

In summary, an 18 year old girl with a severe clinical depression was treated indirectly by working directly with the sub-sets of her social network. It was found that the girl was an emotional scapegoat for several sub-groups in her social network. In part her depression and suicidal behavior may be seen as an acting out of these network conflicts. In addition, the resources immediately available to her in her social network were initially blocked. But resolving these network blockades we were able to afford the girl with a variety of meaningful human relationships which she could accept and use. By continuing consultation with significant persons in her social network it was possible to help them to help the patient with her grief-work, a task that appeared impossible for the psychiatrist to undertake directly with the patient.

Summary:

This paper presents the development of social system psychotherapy. The development of this approach to psychotherapy represents a gradual evolution in clinical practice from a one-to-one interaction to a multiple-person, multi-relational interaction. It also represents the development of a human psychology that has moved from individualistic psychology to social psychology. The techniques of social system psychotherapy are cast in a new model of psychotherapy termed "open" model psychotherapy in contrast to "closed" model psychotherapy. These two models are not competitive but are complementary. An example of social system psychotherapy has been given to indicate how psychotherapy as an intervention with different segments of a social system may be used to treat severe clinical psychopathology. The development of a social system psychotherapy provides a theoretical and technical base for application to many areas of mental health intervention.

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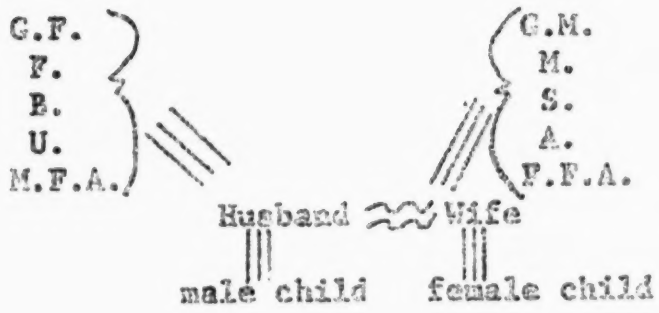
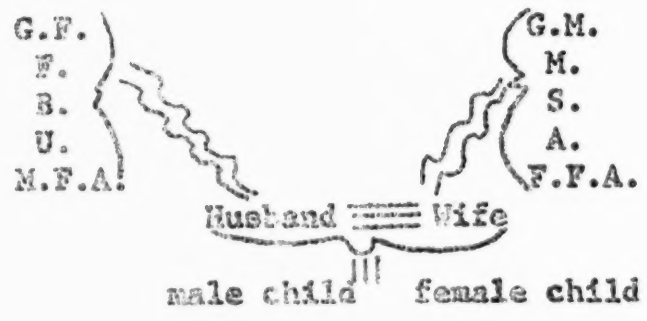
Figure 1

Two polar types of family kin systems and the interrelationship between nuclear family structure and kinship structure.

Close-Knit Family Network



Loose-Knit Family Network



Legends:

G.F. = grandfather
G.M. = grandmother
F. = father
M. = mother
B. = brother
S. = sister
U. = uncle
A. = aunt
M.F.A. = male friends and associates
F.F.A. = female friends and associates

= strong affective linkages

= weak affective linkages

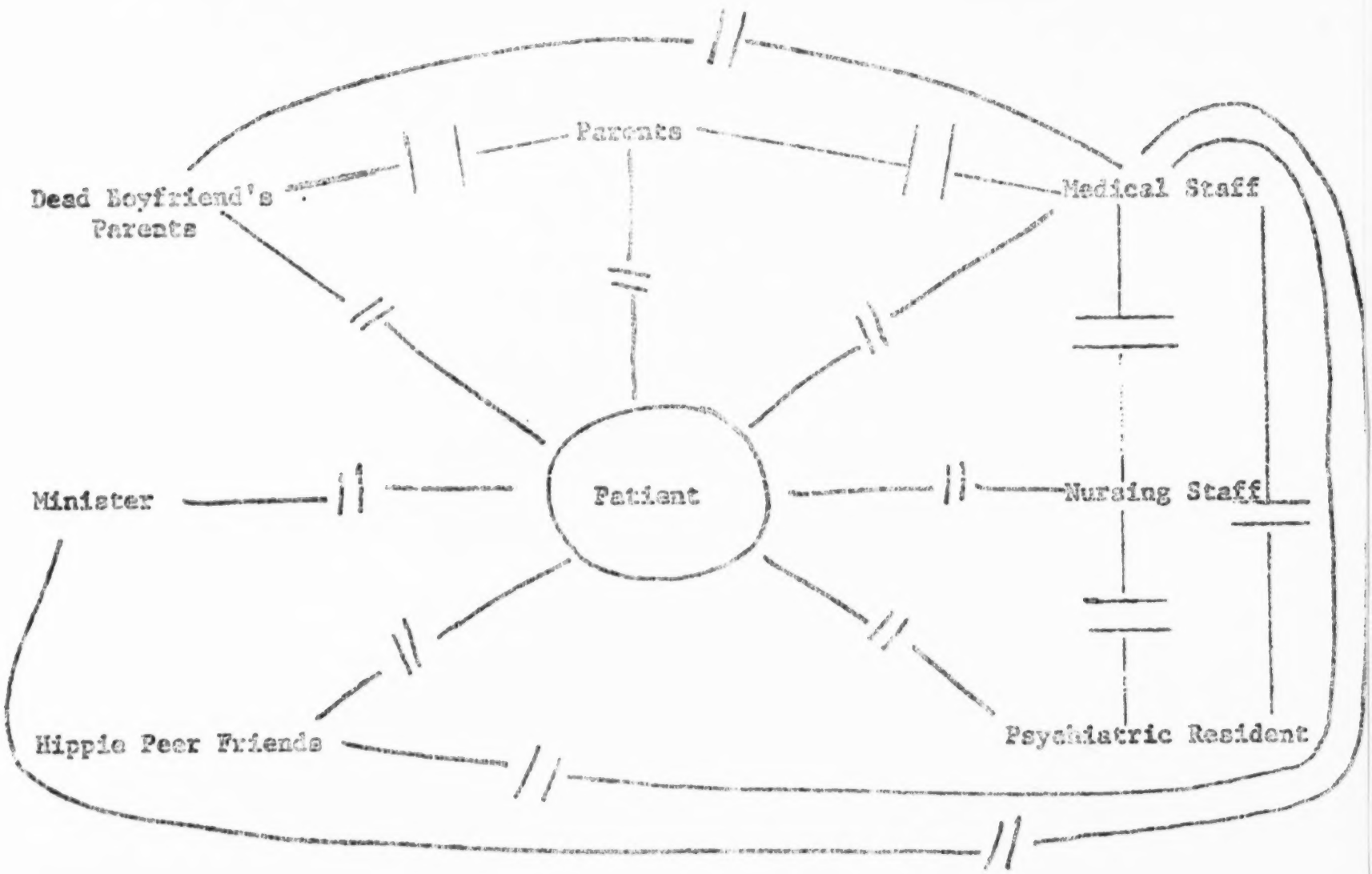
Figure 2.

Two Complementary Models of Psychotherapy

	Closed Model	Open Model
GOAL:	To change personality structure.	To reinforce personality structur (Health patterns of behavior)
PATIENT RELATIONSHIP TO SOCIAL SYSTEM:	May choose to change social systems.	Seeks to return to social system.
THERAPIST RELATIONSHIP TO SOCIAL SYSTEM:	Is given social sanction to stand apart and question.	Is given social sanction to help social system function better.
PSYCHOTHERAPY VIS A VIS THE SOCIAL SYSTEM	Occurs at a distance.	Occurs in the midst.
PRIVACY OF PSYCHOTHERAPY	Of paramount importance.	Anti-therapeutic.
MEMBERS OF PSYCHOTHERAPY	Therapist and patient.	Therapist and social system.
FOCUS OF PSYCHOTHERAPY	Individual patient. (Patient directly)	Total social system. (Patient indirectly)
ROLE OF PSYCHOTHERAPIST	To catalyse capacity of patient to develop self direction.	To catalyse capacity of social system to function more effectively and therapeutically.
DEFINITION OF PATIENT	Self-defined, or deviant as defined by society.	Definition of patient is secondar to definition of social system.
DEFINITION OF THERAPIST	Professionally defined role.	Definition of therapist is secondary to definition of responsible social system.

Figure 3.

PATHOLOGICAL SOCIAL NETWORK OF SUICIDAL TEENAGE GIRL



———||||——— = Blockage of communication and interaction